PRINTED: 07/24/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01 ADDRESS, CITY, STATE, ZIP CODE	(X3) DATE SURVEY COMPLETED 07/02/2012
	PROVIDER OR SUPPLIER GROVE MEADOWS	2002 A	LBANY ST H GROVE, IN 46107	
(X4) ID PREFIX TAG K0000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	A Life Safety Code Recertification, State Licensure and Quality Assurance Walk-thru Survey were conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 07/02/12 Facility Number: 000029 Provider Number: 155072 AIM Number: 100275200 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Beech Grove Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type V (000) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in areas open to the corridor. The facility	K0000	The creation and submission the Plan of Correction does not constitute an admission by the provider of any conclusion set forth in the statement of deficiencies, or any violation regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation arequests a Post Survey Reviet on or after July 31, 2012.	oot is is of of

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

000029

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	TOF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072		LDING	NSTRUCTION 01	(X3) DATE COMPL 07/02 /	ETED
	PROVIDER OR SUPPLIER		p. 1121	STREET A	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	E	(X5) COMPLETION DATE
	all resident sleep	ited smoke detectors in ing rooms. The facility 132 and had a census of f this survey.					
	with state law in	found not in compliance regard to sprinkler oke detector coverage.					
	Code Specialist-Me	Robert Booher, Life Safety dical Surveyor on 07/09/12.					
		found not in compliance ntioned regulatory evidenced by the					

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	(3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
155072 B. WING	07/02/2012
STREET ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER 2002 ALBANY ST	
BEECH GROVE MEADOWS BEECH GROVE, IN 46107	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY)	DATE
K0046 NFPA 101	
SS=F LIFE SAFETY CODE STANDARD	
Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9.	
19.2.9.1.	
1. Based on record review, observation K0046	07/31/2012
and interview: the facility failed to K046 NFPA 101 Life Safety	
document monthly and annual testing of Code standard	
emergency lighting in accordance with	
LSC 7.9 for 13 of 13 battery powered emergancy lights for 12 of 12 months It is the practice of this facility to	
ensure that the documentation is	
LSC 7.9.3 Periodic Testing of Emergency completed monthly and annually	,
Lighting Equipment requires a functional for the emergency lighting system	m
test to be conducted at 30 day intervals in accordance with LSC 7.9.	
and an annual test be conducted on every	
required battery powered emergency	
lighting system for not less than a 1 ½ What corrective action(s) will be	
hour duration. Equipment shall be fully accomplished for those resident	
operational for the duration of the test.	
I I the deticient practice?	
Written records of visual inspections and	
tests shall be kept by the owner for	
inspection by the authority having invisidation. This deficient practice could. There were no residents cited in	.
Jurisdiction. This deficient practice could	
affect any resident, staff or visitor in the	
facility.	
Findings include: How will you identify other	
residents having the potential to	
Based on record review with the	nt
practice and what corrective	
to 11:30 a.m. on 07/02/12, documentation	
of 30 day interval testing and an annual	
test of all thirteen battery powered Facility documentation for battery	у
emergency lights in the facility was not powered emergency lighting is	
available for review. Based on interview implemented and completed	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY							
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED						
		155072	B. WIN	IG		07/02/2012			
NAME OF B	PROVIDER OR SUPPLIEF		•	STREET A	ADDRESS, CITY, STATE, ZIP CODE				
White of TROVIDER OR BUTTELER				2002 A	LBANY ST				
BEECH (GROVE MEADOWS	5		BEECH	I GROVE, IN 46107				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)			
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA				
TAG		LSC IDENTIFYING INFORMATION)	_	TAG	DEFICIENCY)	DATE			
	at the time of rec	<i>'</i>			monthly and annually in accordance with LSC 7.9				
	Environmental S	Supervisor acknowledged			accordance with LSC 7.9				
	no documentation	on of 30 day interval and							
	annual testing of	each battery powered							
	emergency light	was available for review.			What systematic measures wi				
	Based on observ	ations with the			be put into place or what syste				
	Environmental S	Supervisor during a tour			changes will you make to ensu that the deficient practice does				
		om 11:30 a.m. to 2:15			not recur?	´			
	1	2, thirteen battery							
		ncy lights were observed							
	in the facility.	3							
	, ,, ,				Facility will follow facility preventative maintenance				
	3.1-19(b)				manual.				
	3.1-17(0)				- manaan				
	2 Pagad on oha	ervation and interview,			Log implemented to complete				
		·			and document test to test the				
		to ensure 5 of 13 battery			lighting for 1.5 hours in duration	on			
	operated emerge				annually and checked for operation every 30 days.				
		cordance with LSC 7.9.			operation every so days.				
		es battery operated							
		s shall use only reliable							
	1	eable batteries provided			How will the corrective action(size monitored to ensure the	s)			
		ilities for maintaining			deficient practice will not recur				
		charged condition.			i.e., what quality assurance	,			
		such lights or units shall			program will be put into place?	,			
	be approved for	their intended use and							
	shall comply wit	th NFPA 70 National							
	Electric Code. 7	This deficient practice			An audit of the log will be				
	could affect all r	esidents, staff and			reviewed by the Executive				
	visitors.				Director monthly.				
	Findings include	::							
					Compliance Date: 7/31/12				
	Based on observ	ations with the							
	Environmental S	Supervisor during a tour							
	I		1		Î	1			

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	of Correction identification number: 155072	(X2) MULTIPLE CC A. BUILDING B. WING	01	COMPI 07/02	LETED
	PROVIDER OR SUPPLIER GROVE MEADOWS	2002 AI	ADDRESS, CITY, STATE, ZIP COL LBANY ST I GROVE, IN 46107	DE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO) CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
	of the facility from 11:30 a.m. to 2:15 p.m. on 07/02/12, the battery operated emergency light at the Therapy exit and the four battery operated emergency lights inside the weather shell at the emergency generator each failed to illuminate when the test button was pressed five times. Based on interview at the time of observation, the Environmental Supervisor acknowledged the battery operated emergency lights at the aforementioned locations each failed to illuminate when the test button was pressed five times. 3.1-19(b)				

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVI			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 01 COMPLETED			ETED	
		155072	B. WIN			07/02/2012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				LBANY ST		
BEECH (GROVE MEADOWS	3			GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0050 SS=F	NFPA 101 LIFE SAFETY C Fire drills are hel varying condition shift. The staff is and is aware tha routine. Respon conducting drills competent perso exercise leaders conducted between announcement in audible alarms. Based on record facility failed to conducted on the shifts for 2 of 4 c practice affects a facility. Findings include Based on review Report" documental S review from 9:50 07/02/12, there is available for review conducted on the shifts for the thir 2011. Based on record review, the Supervisor acknowledges a fire drill being confired for the shifts of the shifts for the thir 2011 and the shifts for the thir 2011 being confired fire drill being confired for the shifts of the shifts of the shifts of the shifts for the sh	ODE STANDARD Id at unexpected times under its, at least quarterly on each its familiar with procedures it drills are part of established sibility for planning and its assigned only to ons who are qualified to hip. Where drills are seen 9 PM and 6 AM a coded may be used instead of 19.7.1.2 review and interview, the document fire drills its first, second and third quarters. This deficient ill occupants in the interview of a fire drill intation with the upervisor during record in a.m. to 11:30 a.m. on its no documentation item of a fire drill interview at the time of interview at the time of	K00		It is the policy of this facility to have fire drills that are held at unexpected times under varyir conditions, at least quarterly of each shift. The staff is familiar with procedures and is aware drills are part of established routine. Responsibility for planning and conducting drills assigned only to competent persons who are qualified to exercise leadership. Where drare conducted between 9 pm at 6 am a coded announcement may be used instead of audiblical arms. What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice?	ng n that is rills and e	07/31/2012
	fire drill being co	onducted on the first,				y	

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	OF CORRECTION	IDENTIFICATION NUMBER: 155072	A. BUILDING B. WING	01 	COMPLETED 07/02/2012			
	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)	(X5) COMPLETION DATE			
	fourth quarter of 3.1-19(b)	· · · · · · · · · · · · · · · · · · ·		There were no residents cited regard to this regulation.				
				How will you identify other residents having the potential be affected by the same deficient practice and what corrective action will be taken?				
				All residents, staff and visitors have the potential to be affect by the alleged deficient practi	ted			
				What systematic measures w be put into place or what syst changes will you make to ens that the deficient practice doe not recur?	emic sure			
				The maintenance director will document more extensively the conditions of the each fire drill conducted and the type of fire that is being drilled. The time the drills will be varied. A log will maintained to docur	ne II es of			
				the completion of the drills.	niciit.			

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		IDENTIFICATION NUMBER: 155072	A. BUILDING B. WING	01	COMPLETED 07/02/2012			
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE					
	BROVE MEADOWS		2002 ALBANY ST BEECH GROVE, IN 46107					
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)				
				How will the corrective action(see monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?	;			
				The Executive Director or designee will review and sign on the fire drill report monthly, provided by the maintenance department. Any findings will reviewed by the CQI committe and action plans are develope improve performance, which ninclude reeducation and/or disciplinary action.	as be e d to			
				Compliance Date: 7/31/12				

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AND PLAN OF CORRECTION	ES	IDENTIFICATION NUMBER: 155072		A. BUILDING O1		COMPLETED 07/02/2012	
NAME OF PROVIDER OR SUI			D. WILV	STREET A	ADDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN 46107		
PREFIX (EACH DEI	ICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
SS=F LIFE SAFE A fire alarm component installed and Alarm Code fire in any particle to the completing alarm in extinguishing in patient slip provided the 200 feet of located in the written recovered alarm is accordance maintenance. There is reasonable seed and system to a 19.3.4, 9.6 Based on obtaining fire alarms, trouble sign descriptively practice couland visitors. Findings incompared to the same alarms and visitors.	systements, derivative and systements of the sys	•	K00	951	K051 NFPA 101 Life Safety Co Standard It is the practice of this provide have a fire alarm system requi for life safety is installed, tester and maintained in accordance with NFPA 72. The system ha approved maintenance and testing program complying with applicable requirements of NF 70 and 72. What corrective action(s) will be accomplished for those residen	er to red d, ss n PA	07/31/2012

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	OF CORRECTION	IDENTIFICATION NUMBER: 155072	A. BUIL B. WING	DING	01	COMPLETED 07/02/2012	
	ROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST		
BEECH (BROVE MEADOWS			BEECH	GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIENC	CATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
	on 07/02/12 from	g the tour of the facility 11:30 p.m. to 2:15 p.m., primary telephone line			found to have been affected by the deficient practice?	y	
	facility's fire alar to annunciate a tr The facility's fire	m system failed to failed rouble signal locally.			There were no residents cited regard to this regulation.	in	
	laundry room. B time of observations stated the laundry continuously over	nnex to the basement ased on interview at the on, the Administrator y room is not staffed r each shift each day and e facility's fire alarm			How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?		
	•	nnunciate a trouble signal ly to be heard at all			All residents, staff and visitors have the potential to be affected by the alleged deficient practic		
					What systematic measures will be put into place or what syste changes will you make to ensuthat the deficient practice does not recur?	emic ure	
					The primary telephone line for for the facility fire alarm system will be connected at all times. The facility fire alarm will		
					annunciate in a location where staff are present at all times.	•	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED
		155072	B. WING	-	07/02/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIE	R		LBANY ST	
BEECH (GROVE MEADOW	S		I GROVE, IN 46107	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG		
				How will the corrective action(be monitored to ensure the deficient practice will not recu i.e., what quality assurance program will be put into place	r,
				program will be put into place	,
				An environmental CQI tool will utilized weekly x 4 and month	ly
				thereafter to monitor compliar with emergency lighting. The audits are reviewed by the CO	
				committee and action plans at developed to improve	
				performance, which may inclu	de
				reeducation and/or disciplinar action.	
				Compliance Date: 7/31/12	

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	JETIPLE CO	ONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155072	B. WIN	G		07/02/	2012
NAME OF P	ROVIDER OR SUPPLIER			l	ADDRESS, CITY, STATE, ZIP CODE		
555011					LBANY ST		
BEECH (BROVE MEADOWS			BEECH	H GROVE, IN 46107		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0056	NFPA 101	ODE OTANDADD					
SS=E	-	ODE STANDARD omatic sprinkler system, it is					
		dance with NFPA 13,					
		Installation of Sprinkler					
		ide complete coverage for all					
		uilding. The system is					
		ned in accordance with NFPA					
	•	the Inspection, Testing, and Vater-Based Fire Protection					
		lly supervised. There is a					
		e water supply for the					
	•	d sprinkler systems are					
		ater flow and tamper					
	the building fire a	are electrically connected to alarm system. 19.3.5					
	_	ation and interview, the	K00	156			07/31/2012
			IXO	.50	K056 NFPA 101 Life Safety C	ode	07/31/2012
	•	ensure a sprinkler head			Standard		
		of 1 elevator rooms and					
		es Room closets to					
		e for all portions of the			It is the policy of the facility tha	at all	
	•	13 at 5-13.6.2 states			It is the policy of the facility that all required sprinkler heads,		
	•	lers in elevator machine			including those in the activities	5	
		f ordinary or intermediate			room closets and elevator room	ms,	
	•	g. This deficient			are installed.		
	•	fect residents, staff and					
	visitors in the vic	cinity of the Elevator					
	Machine Room is	n the basement and in the			What corrective action(s) will be	e	
	vicinity of the Ac	ctives Room closet.			accomplished for those reside	nt	
					found to have been affected by	y	
	Findings include:	· ·			the deficient practice?		
	-						
	Based on observa	ation with the					
	Environmental S	upervisor during the tour			There were no residents cited	in	
		07/02/12 from 11:30			regard to this regulation.		
	•	, the Elevator Machine					
		ement and the Activities					
	1.00m m the base	mont and the richtines					

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CON A. BUILDING	01	COMPLETED
	155072	B. WING		07/02/2012
	PROVIDER OR SUPPLIER GROVE MEADOWS	2002 AL	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN 46107	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	Room closet did not have a sprinkler head installed. Based on interview at the time of the observations, the Environmental Supervisor acknowledged the Elevator Machine Room in the basement and the Activities Room closet did not have a		How will you identify other residents having the potential be affected by the same defic practice and what corrective action will be taken?	
	sprinkler head. 3.1-19(b) 3.1-19(ff)		All residents, staff and visitors have the potential to be affect by the alleged deficient practic	ed
			What systematic measures w be put into place or what syste changes will you make to ens that the deficient practice doe not recur?	emic ure s
			The facility installed a sprinkle head in the elevator room and activity room closets.	
			How will the corrective action be monitored to ensure the deficient practice will not recu i.e., what quality assurance program will be put into place	r,
			An environmental CQI tool will utilized weekly x 4 and month thereafter to monitor compliar sprinkler heads. The audits a reviewed by the CQI committee and action plans are developed.	ly nce re ee

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	OF CORRECTION	IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE COMPI 07/02	LETED
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP COD LBANY ST	E	
BEECH (GROVE MEADOWS	3		I GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPI DEFICIENCY)		(X5) COMPLETION DATE
				improve performance, when include reeducation and/ordisciplinary action.		
				Compliance Date: 7/31/1	2	

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED
		155072	B. WING		07/02/2012
	PROVIDER OR SUPPLIER		2002 A	ADDRESS, CITY, STATE, ZIP CODE ALBANY ST H GROVE, IN 46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0066 SS=E	Smoking regulation less than the (1) Smoking is proceeded and in any and such area is NO SMOKING of symbol for no smoking by presponsible is produced and in any and such area is NO SMOKING of symbol for no smoking by presponsible is produced and in any and such are provided and in a safe design are provided and in a smoking is permited. And it is a smoking is permited are and in a container with a smoking area where deposited in container with a could affect any vicinity of the end smoking area. Findings include Based on observations in the smoking area.	patients classified as not oblibited, except when under on. concombustible material and provided in all areas where litted. ers with self-closing cover the ashtrays can be emptied able to all areas where litted. 19.7.4 ation and interview, the tensure cigarette butts and a noncombustible self closing lid at 1 of 1 tere employee smoking. This deficient practice staff and visitors in the apployee entrance.	K0066	K066 NFPA 101 Life Safety Constant Standard It is the policy of this facility to have cigarette butts deposited a noncombustible container was a self closing lid. What corrective action(s) will accomplished for those reside found to have been affected by the deficient practice?	d in with be

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/02/2012
	PROVIDER OR SUPPLIER GROVE MEADOWS	2002 AI	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	of the facility on 07/02/12 from 11:30 p.m. to 2:15 p.m., the employee entrance smoking area outside the building had over 100 extinguished cigarette butts on the ground. Based on interview at the time of observation, the Environmental		There were no residents cited regard to this regulation.	d in
	Supervisor acknowledged the facility's employees disposed of cigarette butts on the ground outside at the employee entrance.		How will you identify other residents having the potential be affected by the same defic practice and what corrective action will be taken?	
	3.1-19(b)		All residents, staff and visitors have the potential to be affect by the alleged deficient practi	ted
			What systematic measures w be put into place or what syst changes will you make to ens that the deficient practice doe not recur?	emic sure
			A noncombustible container value a self closing lid was placed in vicinity of the employee entral smoking area	n the
			Department heads make daily rounds in the facility to monitor environmental safety issues. Employees will be reeducated the use on safe depositing of cigarette butts.	d on

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	T OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO A. BUILDING B. WING	01	COMPLETED 07/02/2012
	ROVIDER OR SUPPLIE		STREET . 2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	OBE COMPLETION
				How will the corrective acti be monitored to ensure the deficient practice will not re i.e., what quality assurance program will be put into pla	e ecur, e
				An environmental CQI tool utilized weekly x 4 and mo thereafter to monitor comp with depositing cigarette by the proper container. The are reviewed by the CQI committee and action plan developed to improve performance, which may ir reeducation and/or disciplinaction.	nthly liance utts in audits s are
				Compliance Date: 7/31/12	

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DF CORRECTION IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/02/2012
	ROVIDER OR SUPPLIER GROVE MEADOWS	2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0130 SS=F	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 Based on record review, observation and interview; the facility failed to ensure the continuous operation of 75 of 75 battery operated smoke detectors in 75 of 75 resident rooms. NFPA 101 in 4.6.12.2 states existing life safety features obvious to the public, if not required by the Code, shall either be maintained or removed. This deficient practice could affect all 119 residents, staff, and visitors.	K0130	K130 NFPA 101 Life Safety C Miscellaneous It is the policy of this facility to ensure the continuous operati of battery operated smoke detectors in resident rooms. I compliance with NFPA 101 4.6.12.2	on
	Findings include: Based on record review with the Environmental Supervisor from 9:50 a.m. to 11:30 a.m. on 07/02/12, documentation of monthly battery checks for all resident		What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice?	nt
	room battery operated smoke detectors was not available for review. Based on interview at the time of record review, the Environmental Supervisor acknowledged		There were no residents cited regard to this regulation.	in
	there is no documentation of battery checks for resident room smoke detectors to ensure continuous operation. Based on observations with the Environmental Supervisor during the tour of the facility on 07/02/12 from 11:30 p.m. to 2:15 p.m., battery operated smoke detectors were		How will you identify other residents having the potential be affected by the same defici practice and what corrective action will be taken?	
	observed in all resident rooms. 3.1-19(b)		All residents, staff and visitors have the potential to be affect by the alleged deficient practic	ed

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				(X3) DATE SURVEY COMPLETED	
ANDILAN	or correction	155072	A. BUILDING B. WING	07/02/2012	
	PROVIDER OR SUPPLIE		STREET 2002 /	ALBANY ST H GROVE, IN 46107	•
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)	(X5) COMPLETION DATE
	3.1-19(ff)			What systematic measures w be put into place or what syst changes will you make to ens that the deficient practice doe not recur?	emic sure
				The facility implemented a log document the battery checks smoke detectors in the reside rooms and ensure their continuous operation.	for
				A new smoke detector was installed in each resident roor or before 7.31.12	m on
				How will the corrective action be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place	ır,
				The Executive Director will re and audit the documentation monthly to ensure that the ba checks were completed. Compliance Date: 7/31/12	

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	ENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA N OF CORRECTION IDENTIFICATION NUMBER:			ULTIPLE CO LDING	01	(X3) DATE (COMPL 07/02/	ETED
		155072	B. WIN			07/02/	2012
	PROVIDER OR SUPPLIER			2002 AI	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
	NFPA 101	LSC IDENTIFTING INFORMATION)	+	TAG	BLI TELLICET)		DATE
K0144 SS=F	LIFE SAFETY Conference of the	ODE STANDARD nspected weekly and load for 30 minutes per ance with NFPA 99.					
	the facility failed written record of the starting batter	to ensure a complete weekly inspections of ries for the emergency aintained for 52 of 52	K01	44	K144 NFPA 101 Life Safety C Standard	ode	07/31/2012
	weeks. Chapter a requires storage l connection with a systems shall be not more than 7 d	3-4.4.1.3 of NFPA 99 batteries used in essential electrical inspected at intervals of			It is the policy of this facility to inspect the generator weekly a exercise the load for 30 minut per month in accordance with NFPA 99.	and	
	batteries shall be immediately upo Furthermore, NF checking storage	repaired or replaced n discovery of defects. PA 110, 6-3.6 requires batteries, including			What corrective action(s) will I accomplished for those reside found to have been affected be the deficient practice?	nt	
	than 7 days. Cha requires a writter performance, exe	, at intervals of not more apter 3-5.4.2 of NFPA 99 in record of inspection, ercising period, and nerator to be regularly			There were no residents cited regard to this regulation.	in	
	maintained and a	vailable by the authority on. This deficient fect all residents, staff			How will you identify other residents having the potential be affected by the same defici practice and what corrective action will be taken?		
	Findings include	:			All residents, staff and visitors		
	Based on review	of "Emergency			have the potential to be affect		

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STATEMEN	ATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION			(X3) DATE S	URVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITE	A. BUILDING 01		COMPLE	ETED	
		155072		B. WING		07/02/2	2012	
			b. Wilv		ADDRESS, CITY, STATE, ZIP CODE	L		
NAME OF F	PROVIDER OR SUPPLIEF	₹			LBANY ST			
BEECH (GROVE MEADOWS	5			I GROVE, IN 46107			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TF	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	Generator - Wee	kly Inspection Checklist"			by the alleged deficient practic	e.		
	documentation v	with the Environmental						
	Supervisor durin	g record review from						
	_	30 a.m. on 07/02/12,			What systematic measures will			
		cy generator starting			be put into place or what syste			
					changes will you make to ensu			
		n records for 2011 were			that the deficient practice does			
		review and weekly			not recur?			
	_	ds for the weeks of						
	1 7	through June 29, 2012						
	did not documen	nt starting battery			The facility has implemented			
	inspections. Bas	sed on interview at the			documentation for weekly and			
	time of record re	eview, the Environmental			monthly tests of the generator			
	Supervisor ackno	owledged weekly			accordance with NFPA 99.			
	_	rator battery inspection						
		ty five weeks of the thirty			The maintenance director will			
		of 07/01/11 through			ensure the weekly tests are ra			
		•				no more than 7 days a part and		
	06/29/12 were n	ot available for review.			that the system iniates within 10 seconds.			
					occordo.			
	3.1-19(b)							
	2 Based on reco	ord review and interview,			The maintenance director will			
		to ensure a monthly load			ensure that the monthly test			
					exercises the load of the			
		nergency generators was			generator for 30 minutes.			
		2 of 12 months using one						
		wing methods: under						
		rature conditions, at not			How will the corrective action(۱		
	less than 30% of	the Emergency Power			be monitored to ensure the	·		
	Supply (EPS) na	meplate rating, or loading			deficient practice will not recur	-,		
	that maintains th	e minimum exhaust gas			i.e., what quality assurance			
	temperatures as a	recommended by the			program will be put into place?	?		
	_	Chapter 3-4.4.1.1 of NFPA						
		thly testing of generators						
	*	gency electrical system to			The Executive Director will rev	_{riew}		
		e with NFPA 110.			the documentation weekly to	10 44		
	de ili accordance	WILLINGTA 110.						

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION			(X3) DATE S			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLI	
		155072	B. WIN	IG		07/02/2	2012
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					_BANY ST		
BEECH (GROVE MEADOWS	5		BEECH	GROVE, IN 46107		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
		NFPA 110 requires			ensure that the generator is tested and meets requirements	s of	
	~	Level 1 and Level 2			NFPA 99. All findings that do		
		reised at least once			meet requirement will be broug		
	I	inimum of 30 minutes,			to the CQI governing committe	e	
	~	following methods:			and corrected.		
	_	ng temperature conditions			Compliance Date: 7/31/12		
		n 30 percent of the EPS					
	nameplate rating						
	_	naintains the minimum					
	exhaust gas temp						
	1	the manufacturer.					
		e of day for required					
	_ ~	ecided by the owner,					
	I -	operations. NFPA 99,					
	3-5.4.2 requires a	a written record of					
	inspection, perfo	rmance, exercising					
	period and repair	rs shall be regularly					
	maintained and a	vailable for inspection					
	by the authority	having jurisdiction. This					
	deficient practice	e could affect all					
	residents, staff an	nd visitors.					
	Findings include	:					
	Based on review	.					
	Generator - Wee	kly Exercise/Monthly					
	Load Test Log"	documentation with the					
	Environmental S	upervisor during record					
	review from 9:50	a.m. to 11:30 a.m. on					
	07/02/12, month	ly load test					
	documentation for	or 2011 was not available					
	for review and m	nonthly load testing for					
		ary through June 2012 did					
		e duration of each load					

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	NT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072		LDING	NSTRUCTION 01	(X3) DATE COMPL 07/02 /	ETED
	PROVIDER OR SUPPLIER		B. WIIV	STREET A	DDRESS, CITY, STATE, ZIP CODE BANY ST GROVE, IN 46107	ı	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	E	(X5) COMPLETION DATE
	capacity or the matemperatures recomanufacturer. Butime of record resupervisor acknown test documentation 2011 through Junfor review. 3.1-19(b) 3. Based on recomber facility failed power would be emergency generated building power lower would be and voltage stability failed and meet and voltage stability failed the load and meet and voltage stability failed and work the load and work						

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	OF CORRECTION IDENTIFICATION NUMBER: 155072	A. BUILDING B. WING	COMPLETED 07/02/2012
	PROVIDER OR SUPPLIER GROVE MEADOWS	STREET ADDRESS, CITY, STAT 2002 ALBANY ST BEECH GROVE, IN 4610	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE . CROSS-REFERENCED	IN OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY) TO THE APPROPRIATE IENCY
	Generator - Weekly Exercise/Monthly Load Test Log" documentation with the Environmental Supervisor during record review from 9:50 a.m. to 11:30 a.m. on 07/02/12, monthly load test documentation of emergency power transfer time for 2011 was not available for review and monthly load testing records of emergency power transfer time for January through June 2012 did not document the transfer time from normal electrical power to the emergency generator. Based on interview at the time of record review, the Environmental Supervisor acknowledged monthly load test documentation for emergency power transfer time the period of July 2011 through June 2012 was not available for review. 3.1-19(b)		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 07/02/2012		
NAME OF F	PROVIDER OR SUPPLIER		B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST	0.702	2012
BEECH GROVE MEADOWS				BEECH	I GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	(X5) COMPLETION DATE
K0147 SS=E	NFPA 101 LIFE SAFETY Concentration of the facility on p.m. to 2:15 p.m. for a natural gas housekeeping roow was plugged into Based on intervision observation, the Eupervisor acknown in the housekeeping room and the supervisor acknown in the housekeeping room in the supervisor acknown in the housekeeping room in the supervisor acknown in the housekeeping room in the supervisor acknown in the supervisor ack	DDE STANDARD and equipment is in NFPA 70, National 9.1.2 ation and interview, the ensure 1 of 1 extension ed as a substitute for PA 70, Article 400-8 pecifically permitted, d cables shall not be used a fixed wiring of a efficient practice could not, staff or visitor in the usekeeping room by 01. Ation with the approvisor during the tour 07/02/12 from 11:30, the circulating pump fired water heater in the pump strength of the property of the pump	K01		It is the practice of this facility ensure that extension cords a not used as a substitute for fix wiring. What corrective action(s) will accomplished for those reside found to have been affected by the deficient practice? There were no residents cited regard to this regulation. How will you identify other residents having the potential be affected by the same deficient practice and what corrective action will be taken? All residents, staff and visitors have the potential to be affected by the alleged deficient practice.	re ked be ent by lin to ient	07/31/2012

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	OF CORRECTION	IDENTIFICATION NUMBER: 155072	A. BUILDING B. WING	01 	COMPLETED 07/02/2012
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	
BEECH (SROVE MEADOWS	3		LBANY ST I GROVE, IN 46107	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
				What systematic measures will be put into place or what syste changes will you make to ensuthat the deficient practice does not recur?	emic ure
				The facility removed the extension cord in room 201 an the gas fired water heater is plugged into an approved fixed wiring outlet.	
				How will the corrective action(s be monitored to ensure the deficient practice will not recur i.e., what quality assurance program will be put into place?	;
				An environmental CQI tool will utilized weekly x 4 and monthly thereafter to monitor compliant. The audits are reviewed by t CQI committee and action plantare developed to improve performance, which may include reeducation and/or disciplinary action.	y ce the ns
				Compliance Date: 7/31/12	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155072		(X2) MULTIPLE CONSTRUCTION A. BUILDING D. WING			(X3) DATE SURVEY COMPLETED 07/02/2012		
		155072	B. WIN	_		07/02/	2012
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS				2002 AI	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107		
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OR	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0154 SS=F	Where a required is out of service of 24-hour period, to jurisdiction is not evacuated or an is provided for all the shutdown unbeen returned to Based on record facility failed to juritten policy confollowed in the esprinkler system service for four hour period in act Section 9.7.6.1 in 119 residents. Lesprinkler impairm with NFPA 25, 1 Standard for Insp. Maintenance of Verotection System requires the local notified of sprink 11-5(e) requires alarm company, and other authoricals obe notified. could affect all revisitors.	review and interview, the provide a complete ntaining procedures to be vent the automatic has to be placed out of fours or more in a 24 cordance with LSC, an order to protect 119 of SC 9.7.6.2 requires ment procedures comply 1998 Edition, the foection, Testing and Water-Based Fire ms. NFPA 25, 11-5(d) If fire department be the insurance carrier, building owner/manager ties having jurisdiction This deficient practice esidents, staff and	K01	54	K154 NFPA 101 Life Safety C Standard It is the practice of this facility notify the authority having jurisdiction when the building without service of an automati sprinkler system for more than hours in a 24 hour time period. The building will be evacuated an approved fire watch system will be provided for all parties unprotected by the shutdown the sprinkler system has been returned to full service. 9.7.6.1 What corrective action(s) will be accomplished for those reside found to have been affected be the deficient practice? There were no residents cited regard to this regulation.	to s c 1 4 l of n left until	07/31/2012

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 07/02/2012		
	PROVIDER OR SUPPLIER GROVE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
	and Procedure" documentation with the Environmental Supervisor during record review from 9:50 a.m. to 11:30 a.m. on 07/02/12, Procedure 6 states "Call 911 to report the fire. The facility's ED or designee will notify all necessary entities." The facility's written fire watch		How will you identify other residents having the potential be affected by the same defic practice and what corrective action will be taken?			
	policy stated the necessary entities, which includes the Indiana State Department of Health, alarm company, local fire department, and building owner/manager, would only be notified in the event of a		All residents, staff and visitors have the potential to be affect by the alleged deficient praction	ed		
	fire. Based on interview at the time of record review, the Environmental Supervisor acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health, alarm company, local fire department, and		What systematic measures wi be put into place or what syste changes will you make to ens that the deficient practice doe not recur?	emic ure		
	building owner/manager in the event the automatic sprinkler system is out of service for four hours or more in a 24 hour period. 3.1-19(b)		The Beech Grove Meadows F Watch policy has been update include notification of the India State Department of Health, the fire department, the Fire Alarm Company, building owner, and insurance carrier in the event sprinkler system failure.	ed to ana ne n		
			How will the corrective action(be monitored to ensure the deficient practice will not recu i.e., what quality assurance program will be put into place	r,		

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	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIPLE CC		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	155072	A. BUILDING	01	07/02/2012
		100072	B. WING	A DD DDGG GUTY GT : TO GT	0110212012
NAME OF P	ROVIDER OR SUPPLIER	8		ADDRESS, CITY, STATE, ZIP CODE LBANY ST	
BEECH C	GROVE MEADOWS	3		I GROVE, IN 46107	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		CY MUST BE PERCEDED BY FULL	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DATE
				The fire watch policy will be reviewed annually by the CQ	
				team in accordance with the	
				Disaster Plan review.	
				Compliance Date: 7/31/12	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01			(X3) DATE SURVEY COMPLETED		
		155072	A. BUI B. WIN			07/02/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER					LBANY ST		
BEECH GROVE MEADOWS					H GROVE, IN 46107		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(X5)
PREFIX							COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0155	NFPA 101	ODE STANDARD					
SS=F		d fire alarm system is out of					
		than 4 hours in a 24-hour					
		ority having jurisdiction is					
		building is evacuated or an					
		tch is provided for all parties by the shutdown until the fire					
		is been returned to service.					
	9.6.1.8						
	Based on record	review and staff	K0	155			07/31/2012
	interview, the fac	cility failed to provide a			K155 NFPA 101 Life Safety C	ode	
	complete written	policy containing			Standard		
	_	followed in the event the					
	fire alarm system	has to be placed out of					
	_	nours or more in a 24			It is the practice of this facility	to	
	hour period in ac	ecordance with LSC,			notify the authority having jurisdiction when the building	ic	
	•	n order to protect 119 of			without service of the fire alar		
		his deficient practice			system for more than 4 hours		
		esidents, staff and			24 hour time period. The build		
	visitors.	,			will be evacuated of an approv		
					fire watch system will be provi for all parties left unprotected		
	Findings include	:			the shutdown until the sprinkle		
					system has been returned to t	ull	
	Based on review	of "Fire Watch Policy			service. 9.6.1.8.		
		documentation with the					
		supervisor during record					
		a.m. to 11:30 a.m. on			What corrective action(s) will		
		lure 6 states "Call 911 to			accomplished for those reside found to have been affected by		
	-	The facility's ED or			the deficient practice?	у	
	designee will not	•			and demonstration of		
		cility's written fire watch					
		authority having			There were no residents ''	i	
		Indiana State Department			There were no residents cited regard to this regulation.	111	
		only be notified in the			regard to this regulation.		
		Based on interview at the					

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	of Correction identification number: 155072	A. BUILDING	01	COMPLETED 07/02/2012
	PROVIDER OR SUPPLIER GROVE MEADOWS	2002 A	ADDRESS, CITY, STATE, ZIP CODE LBANY ST I GROVE, IN 46107	1
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE
	time of record review, the Environmental Supervisor acknowledged the written fire watch policy does not state notification of the Indiana State Department of Health would occur in the event the fire alarm system is out of service for four hours or more in a 24 hour period.		How will you identify other residents having the potentia be affected by the same defic practice and what corrective action will be taken?	l l
	3.1-19(b))		All residents, staff and visitors have the potential to be affect by the alleged deficient practi	ted
			What systematic measures we be put into place or what systematic changes will you make to ensure that the deficient practice does not recur?	temic sure
			The Beech Grove Meadows I Watch policy has been updat include notification of the Indi State Department of Health of fire alarm system failure.	ed to ana
			How will the corrective action be monitored to ensure the deficient practice will not recui.e., what quality assurance program will be put into place	ır,
			The fire watch policy will be reviewed annually by the CQ team in accordance with the	I

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	OF CORRECTION	IDENTIFICATION NUMBER: 155072	(X2) MULTIPLE CO A. BUILDING B. WING	01 	COMPL 07/02/	ETED	
NAME OF PROVIDER OR SUPPLIER BEECH GROVE MEADOWS			STREET ADDRESS, CITY, STATE, ZIP CODE 2002 ALBANY ST BEECH GROVE, IN 46107				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ON BE PRIATE	(X5) COMPLETION DATE	
				Disaster Plan review.			
				Compliance Date: 7/31/12			

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